Memo To: Jane Smilie; Joan Bowsher and WIC Study Group
From: MAWA Board of Directors including Mary Pittaway, Connie Undem, Susan Tefre, Jeannine Lund,
Date: March 13, 2008
Subject: Response from to request for input from local agency staff for WIC Study Group

Thanks for inviting input on ways that Montana WIC might be improved. What follows is a list of ideas that have been discussed by our board, with input from others across the state. Thanks for your consideration of the recommendations presented.

1. Institutionalize an **annual coordinated State WIC outreach** effort for WIC that includes targeted advertising in those places with underserved populations. We still need data on the eligible population by region, county or reservation to do this which we understand is being assessed at this time. For example, $25,000 was spent on the most recent WIC outreach effort, but the ads were put on AM radio stations that target the agriculture community listeners. How many new clients were brought in? And how many more would have been brought in if it had been aired in high density areas? As part of the annual plan, include the principal of evaluating outcomes of various outreach strategies rather than repeating ones that don't work. Coordinate WIC outreach with each and every other state run program that is likely to serve families who may be eligible for WIC such as Child and Adult Care Feeding, School meals, Food Stamps, Medicaid, CHIP, LIEAP, TANF, MCH, Children with Special Health Care Needs, etc. It appears that some of this is done, some of the time, rather than a more routine and comprehensive program
2. **Clarify the difference between WIC and MCH**. There continues a perception that WIC is a subset of MCH creating tensions and confusion by local administrators. For example, what are the respective missions, goals, staffing, target population, eligibility criteria, caseloads, annual unduplicated and monthly caseloads, budget, funding source, outcomes, appointments per year and anything that might help compare and contrast the two programs.
   www.whitehouse.gov/omb/expectmore/detail/10003027.2006.html
3. **Set up model of templates for MOUs** and contracts. For example,
   a. WIC MCH Coordination, referrals, shared information.
   b. Running satellite clinics in other counties
   c. Contracts for Registered Dietitian services
4. **Supplemental Funding** When USDA announces RFP's for supplemental WIC grants, Montana should try to apply. For example opportunities for that obesity prevention, whole grain education and others are announced, but Montana doesn't access these funding streams.
5. **Cost allocation:** From 2002 through 2008, the proportion of the money going to local agencies compared to total administrative costs for MT have dropped from 77% of the funds to 68% of the funds. Why? And why has the state cost allocation risen from 20% of total administrative WIC funds for MT in 02, to 35% in 08. In what way is cost allocation negotiable? Who verifies that the charges are fair and reasonable? Which DPHHS programs, if any do not pay cost allocation?
6. **Finish the MOU between WIC and the state IZ** program which was started over 10 years ago. This would allow a seamless immunization records exchange between WIC

and IZ program. Since the state doesn't have an MOU in place, we are told by the state IZ program staff that WIC is losing out on the funding was available through IZ program for sharing of WIC IZ records. And the IZ program is losing out on a substantial number of records available for entry into the registry.

7. **Automated System:** Assure that if data is entered into the automated system locally, reports of that data by clinic site are available. For example if we enter a code for the ethnicity of a client, we should be able to access information on the number of clients with that ethnicity. If we enter the date about exclusive breastfeeding for mothers, we should be able to get a report of the same, etc.
8. **Update training systems**, e.g. the lap top program to train new employees on the WIC system is fraught with errors and bugs and is nothing short of an insult for use in training.
9. Provide **regional dietitians** to cover areas where there are no RDs. Locals could either hire or contract with an RD or contribute to budget to fund a regional RD
10. **Combine the Spring Public Health meeting with the MPHA meeting** to improve attendance at both, to minimize duplication of planning effort, decrease costs and enhance WIC staff's exposure to the broader public health field.
11. Develop a systematic process of soliciting **input and feedback for program changes** from local staff, and/or clients or other affected groups (grocers, physicians, etc). Recent fiascos and costly mistakes, such as eliminating organic foods rather than focus on lower priced brands; pulling out of the computer consortium, and mandating an inappropriate hemoglobin testing system would be avoided. Before making financial decisions, that impact local agencies, send idea out for consideration and comment, including justification (data rather than gut reactions), anticipated outcome etc. If DPHHS were to use data to make decisions and include the data in justifications for changes, buy in and follow-through by local agencies will be enhanced E.g. "Based on x, y, z data, we anticipate food costs will exceed the USDA grant. We propose x, y, z to prevent this problem. E.g "Please comment on the pro's and cons of each of these strategies by x date. "
12. **Limit indirect costs** to a figure lower than the current 25%. All the additional charges to the WIC budget such as rent and indirect, cost allocation, etc drain resources that are needed for basic client services. Could DPHHS approach the **legislature** about funding **cost allocation** expenses charged to WIC by the state agency for a specified period of time, while measures to increase caseload can be put into place? Or permanently? Project the caseload impact MT would see if local agencies were not allowed to charge indirect, rent or administrative services.
13. Encourage **innovated ways of delivery of WIC** nutrition education, especially in the rural and frontier areas. For example, phone follow-up education appointments, email contact with WIC clients, telemedicine education. Share results of pilot studies e.g. web cam education in Eastern Montana.
14. **Routinely send caseload and total food and NSA expenditures** out, by county and reservation to community leaders e.g. county commissioners, mayor, tribal councils etc. This would help to demonstrate the financial impact of WIC in an area. When sharing WIC impact on economic health of communities also include information on how much additional money would be available if full participation were to happen.
15. **Develop a "new to WIC" employee training program** that includes client services, food packages, risk issues, care plan development, referrals, how to manage a clinic, the

computer system, vendor relations, trouble shooting computer problems, all the issues that confront a new employee who now often has to learn this on the job through trial and error. Could WIC 101 be incorporated into an existing annual meeting such as MPHA or the summer Public health institute for Montana?

16. Follow the process used by other states (e.g. Washington State) of not allowing issuance of **non contract formula**. E.g. if Ross has the contract, then Mead Johnson routine formulas aren't allowed. What they do is switch client from powdered formula to concentrated formula as the alternative. This would save MT staff time, and would assure that the full formula rebate on infant formulas was made available to the state. According to DPHHS staff, in MT just last year, almost 6000 non-contract formulas were issued, along with the required MD prescription. It takes local staff an additional 15-30 minutes to process each non contract formula request. Eliminate tracking of returned and then donated **formula**.
17. **Share findings from monitoring visits** (names removed) so all local agencies can benefit from learning of what weaknesses and strengths locals around the state are.
18. Could we figure out a way to decrease the number and frequency of required **signature**s for client appointments? E.g. could we use initials? Combine forms?
19. There are **redundant questions** on breastfeeding through out the documentation process, yet, we still cannot say how many clients breastfeed exclusively for 6 months. Instead of collecting irrelevant data, lets consider using our resources to collect meaningful evaluation information so we can assess which interventions are effective and which are not.
20. We are told that even though congress has approved the **new WIC food packages** which include fresh fruits and vegetables rather than juice products, among other enhancements, Montana will wait until the SPIRIT system is up and running before allowing clients to benefit from these changes. If the implementation could be sped up, our clients and outreach efforts would benefit.
21. Staff **Food Committee** with RD's. The last time authorized foods were removed and added from the Montana program, the "what the client liked" approach led to addition of chocolate milk as an option, (along with the additional 124 calories per cup compared to 1% milk. The highest fiber cereals were eliminated as well as one of the two authorized cereals that provided the full recommended" dose" of folic acid
22. **"WIC Certifiers"** freeing up valuable professional RD, RN and home economist time for higher level services. We are told that our regional office doesn't like certifiers. So what, if it s allowed under the regulations, we should consider doing it. That way para-professional staff could perform certification and food package assignment duties, as part of the routine certification appointment. Those clients with specific nutritional risks would be seen by an RD, but many WIC clients only require routine care, which could be handled by RD driven protocols.
23. Could the state research and present how WIC RD's could augment funding through billing Medicaid, EPSTD and CHIP for nutrition care services? Most local agencies are not currently providing or billing for these services. Also the reimbursement for RD services would enhance client access to expert care for metabolic disorders, diabetes and other endocrine anomalies, Cystic fibrosis, food allergies, GI illness, and any number of conditions requiring nutrition therapy. Can DPHHS create a service delivery model, forms, etc to assure access to funding for RD services under the MCH program? This process works in other states, why not Montana?

24. Eliminate **requiring proof of pregnancy** for certification of prenatal clients, except if there is question as to the pregnancy. It is optional. (Page 331 WIC regulations.

> ii) For a State agency opting to require proof of pregnancy, the State agency may issue benefits to applicants who claim to be pregnant (assuming that all other eligibility criteria are met) but whose conditions (as pregnant) are not visibly noticeable and do not have documented proof of pregnancy at the time of the certification interview and determination. The State agency should then allow a reasonable period of time, not to exceed 60 days, for the applicant to provide the requested documentation. If such documentation is not provided as requested, the woman can no longer be considered categorically eligible, and the local agency would then be justified in terminating the woman's WIC participation in the middle of a certification period.

27. Montana' State plan requires that **hemoglobin testing** be done for infants and children at 9, 12, 18 and 24 months and then once each year thereafter if result is normal. The federal regulations require hemoglobin's be done at 9, 15, 26 months and then once a year there after, if result is normal. This additional hemoglobin test results in an additional 5500 tests at $1.24 per test. Extra testing costs tax dollars and adds an additional invasive procedure with it's inherent risk. It increases the work load of local staff, not to mention the increased apprehension of the parent. Locals are told that one by one, we can petition to do the process differently, but why not change it for all at once? Even after a pilot program in 2005 was run for over a year in two clinics, showing that the additional test wasn't warranted, a statewide change has not been made. Here is the break down of the cost of supplies for a single hemoglobin test: So it looks like a total of around $1.24-1.39

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| Alcohol swab... | $.02 |
| Gloves... | $.13 |
| Lancet... | $.25 -.34 |
| Microcuvette... | $.79 |
| Band-aids... | $.05-.11 |

28. Could Montana go back to putting **the maximum food price** on vouchers as allowed in the federal regulations? This will curtail the "lowest price" enforcement issue, as indicated on page 358 of the Federal Regulations (see below)

> (vi) *Purchase price.* A space for the purchase price to be entered. At the discretion of the State agency, a maximum price may be printed on the food instrument that is higher than the expected purchase price of the authorized supplemental foods for which it will be used, but that is low enough to protect against potential loss of funds. When a maximum price is printed on the food instrument, the space for the purchase price must be clearly distinguishable